CLIENT INFORMATION SHEET

Name:____ Date of Birth:__________________
Address:____
____
Home phone:________________ Cell phone:________________ Work phone:________________
May we contact you at these numbers? ____
Emergency contact:____

Procedure(s) desired:

____ Upper Eyeliner ____ Eyebrows ____Lipliner ____Beauty Mark ____Areolas

____ Lower Eyeliner ____Scar Camouflage ____Full Lips ____Other:__________________

Have you **EVER** had a cold sore/fever blister/herpes around the mouth? ____Yes ____No

If yes, a prescription for Zovirax or some other anti-viral medication will be required prior to any lip procedure.

I have read the above information regarding an anti-viral and understand its use is mandatory if I desire a lip procedure.

*Signed:_______________________________________(Client)

Are you currently under the care of a physician? ____Yes ____No
If so, why? ____
Physician's name: ____

Do you take antibiotics when going to the dentist? ____Yes ____No If yes, why? ______________________

Do you suffer from: ___Allergies ___Moles or freckles at site of tattoo ___Hepatitis ___Heart Problems

___Hemophilia ___Diabetes ___Skin Problems ___Eye Problems ___Epilepsy ___Chapped lips

___Bruise or bleed easily ___Healing problems ___High blood pressure ___Autoimmune disorders

___Any keloid or hypertrophic scars – location? ________________________________

Do you have allergies to: ___Bacitracin or Neosporin ___Latex rubber ___Lidocaine ___Metals:___________

Have you ever had: ___Collagen injections – location: ____________________________
___Fat transfer injections – location: ___________________________
___Gore-Tex implants – location: ______________________________

Are you presently taking any medication which thins the blood? ____Yes ____No
Are you taking other medications including anti-depression or mood altering drugs? ____Yes ____No
If yes, explain: ____

Are you pregnant or nursing? ____Yes ____No

Do you wear contact lenses? ____Yes ____No

If you are planning any facial cosmetic surgery or other facial surgery in the future, please describe: ___________
____

The above is complete and accurate as to my medical history.

*Signed:____(Client) Date:_______________